COUNTY OF LOS ANGELES
DEPARTMENT OF AUDITOR-CONTROLLER

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WENDY L. WATANABE
AUDITOR-CONTROLLER

May 7, 2013

TO: Supervisor Mark Ridley-Thomas, Chairman
Supervisor Gloria Molina
Supervisor Zev Yaroslavsky
Supervisor Don Knabe
Supervisor Michael D. Antonovich

FROM: Wendy L. Watanabe
Auditor-Controller

SUBJECT: **SOUTH BAY CHILDREN'S HEALTH CENTER – A DEPARTMENT OF MENTAL HEALTH CONTRACT SERVICE PROVIDER – PROGRAM REVIEW – FISCAL YEAR 2011-12**

We completed a contract compliance review of South Bay Children's Health Center (South Bay or Agency), which included a sample of billings from November and December 2011. The Department of Mental Health (DMH) contracts with South Bay to provide mental health services, including interviewing Program clients, assessing their mental health needs, and implementing treatment plans. The purpose of our review was to determine whether South Bay provided the services and maintained proper documentation, as required by their County contract.

DMH paid South Bay approximately $900,000 on a cost-reimbursement basis for Fiscal Year 2011-12. The Agency provides services in the Fourth Supervisorial District.

Results of Review

South Bay's staff had the required qualifications to provide DMH Program services. However, South Bay needs to improve the quality of documentation in their Assessments, Client Care Plans, and Progress Notes. Specifically, South Bay:

- Did not adequately describe the clients' symptoms and behaviors to support the diagnosis for 17 (85%) of the 20 Assessments reviewed.

- Did not develop specific objectives in the Client Care Plans for eight (40%) of the 20 cases reviewed.

- Did not describe what the clients or service staff attempted and/or accomplished towards the clients' goals on 12 (43%) of the 28 Progress Notes reviewed.

  South Bay's attached response indicates that the Agency provided trainings to their treatment staff and revised their documentation training manual to ensure that their Assessments, Client Care Plans, and Progress Notes are completed in accordance with the DMH contract requirements.

Details of our review, along with a recommendation for corrective action, are attached.

Review of Report

We discussed our report with South Bay and DMH. South Bay's attached response indicates that they agree with our findings and recommendation.

We thank South Bay management for their cooperation and assistance during our review. Please call me if you have any questions, or your staff may contact Don Chadwick at (213) 253-0301.

WLW:AB:DC:EB

Attachment

c: William T Fujioka, Chief Executive Officer
Dr. Marvin J. Southard, Director, Department of Mental Health
Lisa Montes, Chair, Board of Directors, South Bay Children's Health Center
Tina Harris., Executive Director, South Bay Children's Health Center
Public Information Office
Audit Committee

SOUTH BAY CHILDREN'S HEALTH CENTER
DEPARTMENT OF MENTAL HEALTH
FISCAL YEAR 2011-12

BILLED SERVICES

Objective

Determine whether South Bay Children's Health Center (South Bay or Agency) provided the services billed in accordance with their Department of Mental Health (DMH) contract.

Verification

We selected 42 (28%) of the billings from 148 approved Medi-Cal billings for November and December 2011, which were the most current billings available at the time of our review (August 2012). We reviewed the Assessments, Client Care Plans, and Progress Notes in the clients' charts for the selected billings. The 42 billings represent services provided to 20 clients.

Results

South Bay maintained documentation to support 96% of the billings sampled. However, the Agency needs to improve the quality of documentation in their Assessments, Client Care Plans, and Progress Notes.

Assessments

South Bay did not adequately describe the clients' symptoms and behaviors consistent with the Diagnostic and Statistical Manual of Mental Disorder (DSM) to support the diagnosis in 17 (85%) of the 20 Assessments reviewed. The DSM is a handbook published by the American Psychiatric Association for mental health professionals, which lists different categories of mental disorder and the criteria for diagnosing them. The DMH contract requires the Agency to follow the DSM when diagnosing clients.

Client Care Plans

South Bay did not complete some elements of eight (40%) of the 20 Client Care Plans in accordance with their DMH contract. Specifically, the Agency did not develop specific objectives for goals.

Progress Notes

South Bay did not describe what the clients or service staff attempted and/or accomplished towards the clients' goals in 12 (43%) of the 28 Progress Notes billed to DMH.

Recommendation

1. **South Bay management ensure that Assessments, Client Care Plans, and Progress Notes are completed in accordance with their DMH contract.**

STAFFING QUALIFICATIONS

Objective

Determine whether South Bay's treatment staff had the required qualifications to provide the services.

Verification

We reviewed the California Board of Behavioral Sciences' website and/or the personnel files for eight of the 13 South Bay treatment staff, who provided services to DMH clients during November and December 2011 and January 2012.

Results

Each employee reviewed had the qualifications required to provide the billed services.

Recommendation

None.

SBCHC
South Bay Children's Health Center

January 28, 2013

Department of Auditor-Controller
Kenneth Hahn Hall of Administration
500 West Temple Street, Room 525
Los Angeles, CA 90012-3873
Attention: Wendy Wantanabe

RE: South Bay Children's Health Center's Corrective Action Plan following Contract Compliance Review for Fiscal Year 2010-2011

Dear Ms. Wantanabe:

Attached please find our Corrective Action Plan in response to the Contract Compliance Review for Fiscal Year 2010-2011 that was conducted in August 2012.

Please let me know if you have any questions or need additional information. I can be reached at (310) 316-1212, or by email at cbyrne@sbchc.com.

Sincerely,

Christine Byrne, MFT
Deputy Director

Enclosure

CORRECTIVE ACTION PLAN IN RESPONSE TO CONTRACT COMPLIANCE

REVIEW FOR FISCAL YEAR 2010-2011

SOUTH BAY CHILDREN'S HEALTH CENTER

Findings:

1. South Bay Children's Health Center did not adequately describe the client's symptoms and behaviors to support the diagnosis in 85% of the Assessments reviewed.

2. South Bay Children's Health Center did not complete the Client Care Plan goals for 40% of the clients reviewed.

3. South Bay Children's Health Center did not describe what the clients or service staff attempted and/or accomplished towards the client's goals in 43% of the Progress Notes reviewed.

Corrective Action:

In October 2012, our Clinical Director trained all staff based on the feedback we received from the Contract Compliance Auditor. The training focused on all the documentation issues that were noted by the auditor. This training also focused on the Clinical Loop to ensure this documentation continues appropriately throughout the clinical file. In addition, our Clinical Utilization Review supervisor has been trained to ensure that staff is implementing this feedback in their documentation, and working with new and existing staff to ensure proper documentation is provided. We have also included this information in the documentation training manual that we provide our staff for their reference when they are completing DMH required paperwork. Attached is a copy of the training that was provided. This corrective action has been already implemented and documentation is being reviewed regularly to ensure that staff is documenting appropriately.

UR Training October 2012
Feedback and Training from August 2012 Audit

Diagnostic Issues

- Anxiety Disorder NOS: this (and all other NOS DX) are designed for use when no other diagnosis better fits the presenting symptoms. The Auditor felt that this was diagnosed was over used and that the symptoms/behaviors presented could be better accounted for by another diagnosis.
- The auditor emphasized importance of listing SPECIFIC behaviors and not just the symptoms. The feedback about diagnosis problems wasn't that the diagnose were totally off, but that the list of symptoms were too vague to properly support a diagnosis and that is why we relied too much on "NOS" Dx.
- The key to addressing this issue is to get SPECIFIC BEHAVIORS from CLs and Caregivers. For example...
    - "Irritability": what does this look like? Where does it happen? In what situations? Describe the behavior that can be seen, not just the label "Irritable."
    - "worries": worries about what? In what settings? How do the worries cause function impairment (see below for more on this)?
- "Per history" Diagnoses are ok but must be a secondary diagnosis. We must diagnosis CURRENT symptoms/behaviors as primary and this must be focus of treatment. If the primary DX has already been given but continues to meet full criteria, don't write "per history." In general be careful with "per history" on DX.

Clinical Loop (see attached)

- Main point here is that we are not explaining/describing FUNCTIONAL IMPAIRMENT well enough. Symptoms do not by themselves justify medical necessity. The CL must be having impairment in his/her functioning caused by those symptoms. We KNOW this, but are not properly documenting/explaining this.
    - Detailed explanations about how the symptoms are causing impairment. For example: "Client experiences excessive worries about not living parents, going to a different foster home, trauma memories, spiders, failing at school, bullying. . These worries cause impairment at school due to intrusive thoughts disrupting concentration. Client is failing three subjects and reports difficulty maintaining attention due to worries."
    - Describe the symptoms more thoroughly for example: Client experiences angry outburst (yelling, screaming, throwing objects, banging head against the wall)

and these outburst cause impairment at home due to increased conflict with MO, safety concerns related to banging of head, destruction of property.

- Again, this is information we KNOW and incorporate into treatment- we just need to spell it out in great detail.
- ***These symptoms cause functional impairment for client by...*** needs to be specifically spelled out in assessments (page 2), in first progress note and all medical necessity related notes, and weekly in progress notes, and in CCCP goals.
- ***Sample Prompts to help with specific descriptions and linking to functional impairment:*** what is the situation, what does this symptom mean, what does it look like, when does it happen, what is the specific behavior, "give me an example" "what does that look like" "How does that make (school, home, etc) harder?

Progress Notes

- The "S" must be specifically link back to a CCCP goal and a behavior that is being treated. This links back to the idea of linking symptoms to specifically described behaviors (see above) and the functional impairment caused by this symptom
- In the body of the progress note, make sure to describe how the symptom is linked to functional impairment. The key here is to state the words "functional impairment" linked to specific behaviors (not just symptoms).
- Don't use the phrase "checked in" in with caregiver. Auditor did not think this sounded therapeutic. Instead you could say "asked Caregiver for feedback about functional impairments, asked caregiver about CL's specific behaviors, provided empathic listening and support, provided information about, provided parenting psycho-education, etc. "
- Auditor said we should better describe the process by which we are helping the caregiver and that seeming like we are "checking in" is not including them in treatment.
- In family sessions, make sure you are focusing on how this related to client's functional impairment, how this addresses specifically described behaviors and will increase Cl's functioning at home.

General UR Notes

- Discharge Summary: auditor wanted more detail in the description of what treatment occurred. I know there is limited space but be as detailed as you can here. Make sure clearly explain specific behaviors in the presenting symptoms.
- CCCP: make sure you are measuring only ONE specific behavior (not "reduce depressive symptoms AEB reduction in angry outburst, sad mood, irritability) etc. Make sure you

are choosing ONE symptom and then DESCRIBING THE ACTUAL BEHAVIOR (best example: angry outburst and excessive worry examples above)

- If you are adding a CCCP goal in an EXISTING CCCP (not starting a new one) USE THE ADDENDUM PAGE to add a goal- don't rip off page one of a brand new CCCP. We end up with blank "long term goals" and the goal numbering becomes off too.
- At annual- start an ENTIRE NEW CCCP including goal page, signature page, cycle page. DO NOT add new goals completed at annual on to an old CCCP. Must start over.
- On Annual assessment- make sure you are correctly explaining how they meet medical necessity including specific functional impairments to justify current services (beware of meds only/tcm)
- On discharge summary- LOTS of missing Axis IV and referral out code. Check your electronic version!!
- Make sure to have MFT LCSW etc written after your signature and then typed License and number and name.
- On CCCP for outcomes- if closing write "goal met, discharge due to.... or "goal not met, discharge due to transfer, CL withdrew/stopped coming. Etc).